UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

No. 142—August Term 1991

Argued: August 28, 1991 Decided: February 3, 1992

Docket No. 91-6123

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION; MEDICAL SOCIETY OF THE STATE OF NEW YORK; SIDNEY FINKEL and JOHN A. BLESKI,

Plaintiffs-Appellants,

—against—

CESAR A. PERALES, as Commissioner of Social Services of the State of New York and LOUIS W. SULLIVAN, M.D., as Secretary of the United States Department of Health and Human Services,

Defendants-Appellees.

Before:

OAKES, *Chief Judge*,
FEINBERG and CARDAMONE, *Circuit Judges*.

Appeal from order and judgment of dismissal by the United States District Court for the Southern District of New York, Mary Johnson Lowe, J. Plaintiffs contend that the district court erred in upholding a New York regula-

tion, 18 NYCRR 360.10, under the Medicare and Medicaid Acts.

Reversed. Judge Cardamone dissents in a separate opinion.

PETER F. NADEL, New York, NY (Rosenman & Colin, Joseph V. Willey, of Counsel; LeBoeuf, Lamb, Leiby & MacRae, New York, NY, Jay G. Safer, Ronald J. Gizzi, of Counsel), *for Plaintiffs-Appellants*.

KAY K. GARDINER, New York, NY, Assistant United States Attorney for the Southern District of New York, Otto G. Obermaier, United States Attorney for the Southern District of New York, Marla Alhadeff, Assistant United States Attorney, of Counsel), *for Defendant-Appellee Sullivan*.

FEINBERG, *Circuit Judge*:

This case involves a challenge to New York State's elimination of the rights of health care providers to receive reasonable compensation when they treat poor Medicare patients. Plaintiff-appellant New York City Health and Hospitals Corporation is a New York public benefit corporation created by New York State. It is a principal provider of hospital services to the low-income population of the City. Plaintiff-Appellant Medical Society of the State of New York, the largest voluntary association of physicians in New York, is a non-profit

corporation organized and existing under the laws of New York State. Plaintiffs-appellants Sidney Finkel, M.D. and John A. Bleski, M.D. are physicians who participate in the Medicare program; many of their patients are eligible under both Medicare and Medicaid. Defendant-appellee Cesar A. Perales is the New York State Commissioner of Social Services. Defendant-appellee Louis W. Sullivan, M.D., is Secretary of the United States Department of Health and Human Services (the Secretary). Perales concurs with the views of Sullivan as set out in his brief.

Appellants appeal from a judgment of the United States District Court for the Southern District of New York, Mary Johnson Lowe, J., dismissing plaintiffs' complaint challenging a regulation of the New York State Department of Social Services as violative of the Medicare Act, Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395ccc, and the Medicaid Act, Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, et seq. The Medicare program provides funds that help subsidize medical care for the elderly and for certain disabled individuals. The Medicaid program subsidizes medical assistance for the poor.

Appellants claim that the regulation at issue, N.Y. Comp. Codes R. & Regs. tit. 18, § 360.10 (1988),[1] which has been approved by the Secretary, violates the Medicare and Medicaid Acts. For the reasons given below, we agree. Accordingly, we reverse and remand with directions to grant summary judgment for appellants.

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1 Effective March 1, 1989, 18 NYCRR § 360.10 was repealed and recodified as 18 NYCRR § 360-7.7. For purposes of consistency, the regulation will be referred to as "the Regulation."

I. Introduction

Before addressing the merits of the controversy before us, it is important that we clarify various terms of the relevant statutes. Under the Medicare Act, the federal government provides people who are 65 years of age and older and certain disabled individuals (people who are Medicare-eligible) with an inpatient hospital insurance plan known as "Part A". 42 U.S.C. §§ 1395c-1395i-4. The Medicare Act also provides that people who are Medicare-eligible may voluntarily obtain supplementary insurance for other medical care, including certain physician services, hospital outpatient services, and other health services generally not covered under Part A. 42 U.S.C. §§ 1395j-1395w-4(j). This coverage is known as "Part B" and is the part of the Medicare statute involved in this appeal. To obtain this coverage, a Medicare-eligible person must pay insurance premiums. Once Part B coverage is obtained, the federal government pays 80% of the "reasonable costs" of outpatient hospital services and 80% of "reasonable charges" for physician services rendered to the insured. Reasonable costs and charges are established pursuant to the Medicare Act and regulations. Medicare patients themselves are responsible for paying the remaining "coinsurance" amount (20% of the reasonable costs of hospital services and 20% of the reasonable charges for physician services) and the annual deductible

The Medicaid Act, a statute separate from the Medicare Act, provides for a joint federal and state funded system which subsidizes medical care for the needy, regardless of age. If a state decides to participate in Medicaid, it proposes a plan which must be approved by the Secretary as conforming with federal requirements. 42 U.S.C. §§ 1396a(a), 1396a(b). The plan must include, among

other things, a schedule of payment rates which the state designates for the various kinds of medical care that a Medicaid patient might seek. Id. If the Secretary approves a state's plan, then the Federal government will assist the state in its reimbursement program with federal Medicaid funds. Those doctors and hospitals who are willing to treat Medicaid patients must agree to accept the designated Medicaid rate and not ask the patient to pay any money beyond that amount. 42 U.S.C. §§ 1320a-7b(d), formerly 42 U.S.C. § 1396h(d), and 42 C.F.R. § 447.15 (1989). New York State is a participant in the Medicaid program.

Returning to Medicare, the authors of the statute recognized in addressing the needs of Medicare patients that the poor Medicare-eligible (those who are eligible for Medicaid as well) generally would not be able to afford to enroll in the optional Part B Medicare coverage described above, because they would not be able to pay the insurance premiums, the 20% coinsurance and the annual deductible. The Act therefore provides, in 42 U.S.C. § 1395v, as elaborated by 42 C.F.R. § 407.40-407.50 (1990), that a state may agree to pay Part B Medicare insurance premiums on behalf of such poor elderly and disabled—whom we shall call "dual eligibles" or "crossovers"—and thereby acquire Part B Medicare coverage for them. By so doing, a state enrolls these crossovers in the Medicare Part B program just as less needy individuals enroll themselves when they individually choose to obtain Part B Medicare coverage and pay the insurance premiums. The federal government contributes funds to subsidize these state "buy-in" arrangements. New York has such a buy-in agreement with the Secretary.

Until 1987, New York paid not only the premiums but also the full cost-sharing amounts—the annual deductible and the 20% of reasonable costs or charges beyond what Medicare covers—for buy-in crossovers. Effective January 1, 1987, however, New York changed its practice by enacting the Regulation at issue in this case. The Regulation provided that in the case of crossovers covered by Part B through a buy-in agreement, New York will not pay any cost-sharing amounts except under one set of circumstances: When the 80% of reasonable costs or charges that Medicare reimburses amounts to less than the *Medicaid* rate, New York will pay the difference (Medicaid rate minus 80% reasonable costs or charges). A letter sent by New York State to health care providers illustrates the way that the Regulation operates:

> *Example*: Medicaid Fee or Rate = $45.00
>
> | *Medicare Approved* | *[80%] Medicare Paid* | *Balance Due* |
> |---|---|---|
> | $80.00 | $63.00 | $0.00 |
>
> A claim *should not* be submitted to Medicaid in this example.
>
> * * *
>
> *Example*: Medicaid Fee or Rate = $50.00
>
> | *Medicare Approved* | *[80%] Medicare Paid* | *Balance Due* |
> |---|---|---|
> | $60.00 | $48.00 | $2.00 |
>
> A claim *should* be submitted to Medicaid for the amount of $2.00.

The Regulation also prohibits Medicare providers from collecting any money from buy-in dual eligibles themselves.

One effect of the Regulation is that in New York State a dual eligible's providers may almost never collect more than 80% of their reasonable costs or charges, because the scheduled Medicaid payments are almost invariably less than 80% of the corresponding reasonable costs or charges of a given type of care under Medicare.[2] The Regulation has been modified to extend to a group of Medicare-eligible patients who are not poor enough to qualify for Medicaid but have incomes at or below the poverty line. This group is referred to as "qualified Medicare beneficiaries" (QMBs). 42 U.S.C. §§ 1396d(p)(1), 1396d(p)(2)(A). The QMBs may, like dual eligibles, be provided with Part B coverage through a buy-in agreement. 42 U.S.C. § 1396d(p)(3). The modified New York regulation limits New York's contribution to QMBs' cost-sharing coverage in the same way it does that of dual eligibles, on the basis of Medicaid rates.

II. Procedural History

This appeal arises out of a challenge to the Regulation as violative of the Medicare and Medicaid Acts. The Regulation has been approved by the Secretary. The approval was apparently not accompanied by an opinion or statement of reasons, and, we are told, was issued after commencement of this litigation. As indicated above, the Regulation became effective January 1, 1987. In the district court, plaintiffs and defendants both moved for sum-

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2 Because the record reflects that this conclusion is true and appellees do not dispute it, we shall assume that it is true and that New York in most cases now pays no part of Part B cost-sharing amounts.

mary judgment and defendants also moved to dismiss. While these motions were pending, Congress amended portions of the Social Security Act relevant to the action, and the parties addressed the effect of the amendments in letters to the district court. In an opinion and order dated March 18, 1991, the district court denied plaintiffs' motion and granted defendants' motions for dismissal of the complaint. The court reasoned that the Secretary's approval of the Regulation was based upon a permissible construction of the statute and that his interpretation was therefore entitled to deference. Thereafter, judgment was entered but subsequently vacated to permit plaintiffs to file an amended complaint, which included a new count based on amendments to the Medicaid Act that took effect in 1989. In April 1991, the district court entered a final judgment dismissing the amended complaint. This appeal followed.

III. Discussion

In this action, we must determine what New York State's responsibility is under the Medicare and Medicaid Acts for the annual deductible and 20% of reasonable costs or charges for patients who are dual eligibles or QMBs.

Appellants claim that the Regulation violates the Medicare and Medicaid Acts and that the Secretary's approval of the Regulation is unjustified. Appellees submit that under Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 844 (1984), we are required to defer to the Secretary's interpretation of the statute at issue unless the interpretation is "manifestly contrary" to the statute. Although we recognize, as did the district court, that the Medicare and Medicaid Acts are very com-

plicated, this is one of those comparatively rare instances when we should not defer to an administrator's interpretation of a statute. First, as we explain below, the Regulation is at odds with the clear intent of the statutes, both facially and as elaborated by legislative history. See Chevron, 467 U.S. at 842-43. Second, the Secretary's policy has been inconsistent with respect to the particular question at issue, and his current position is therefore entitled to less deference.

Medicare Act

Under the Medicare Act, a provider of services to a Medicare-eligible individual pursuant to the Medicare Act receives from the federal government, after deduction of the annual deductible, 80% of the reasonable costs or charges for such services. To collect the remaining portion of the provider's compensation, the provider "may charge such [Medicare-eligible] individual or other person (i) the amount of any deduction . . . and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services . . . for which payment is made under part B . . . ." 42 § 1395cc(a)(2)(A). In other words, providers who furnish medical care to Medicare-eligible patients have the right to collect 100% of their reasonable costs or charges. Mercy Community Hosp. v. Heckler, 781 F.2d 1552, 1556-57 (11th Cir. 1986); St. James Hosp. v. Heckler, 760 F.2d 1460, 1472 (7th Cir. 1985), cert. denied, 474 U.S. 902 (1985); Menorah Medical Center v. Heckler, 768 F.2d 292, 296 (8th Cir. 1985); Regents of Univ. of Cal. v. Heckler, 771 F.2d 1182, 1188-89 (9th Cir. 1985). As appellants note, there is nowhere articulated in the Medicare Act or regulations an exception for dual eligibles or QMBs or any limitation on providers' express statutory right to recover their full reasonable costs or charges.

Despite this right, the Regulation at issue limits New York State's cost-sharing contribution to the Medicaid rate, an amount that is less than a provider's reasonable costs or charges, and prohibits providers from collecting anything from the patients themselves. In other words, the Regulation precludes providers who serve dual eligibles and QMBs pursuant to a buy-in arrangement from collecting more than 80% of their reasonable costs or charges in the overwhelming majority of cases.

The Regulation therefore appears, on its face, to violate the Medicare Act. The Secretary has nevertheless approved it, on the ground, accepted by the district court, that dual eligibles and QMBs are "primarily Medicaid patients" since they receive Part B Medicare coverage only because the State has enrolled them due to their status as Medicaid patients or poor individuals. In the Secretary's understanding, then, providers supplying care to such individuals are therefore not entitled to receive their reasonable costs or charges. We do not accept this reasoning. The Medicare Act on its face entitles providers to collect their reasonable costs or charges, an entitlement which is frustrated by the Regulation.

The Secretary's interpretation of dual eligibles as primarily Medicaid patients leads to some oddities. If Medicaid alone controlled with respect to dual eligibles, then it would make little sense for Medicare Part B to pay 80% of the Medicare rate for crossover care. If Medicaid were in fact the controlling program, then one would expect providers to be compensated at the Medicaid rate, instead of at 80% of the Medicare rate. Moreover, if crossovers were "primarily Medicaid patients," there would be no basis for Medicare to allow (as it does), as a hospital's bad debt expense, the uncollected Medicare cost-sharing amounts.

Beyond the face of the statute, the Senate Report accompanying the initial Medicare Act reveals that Congress sought to avoid a wealth-based, two-tiered system of health care for the elderly and certain disabled and indeed wanted to integrate *all* of those who were Medicare-eligible into the existing health care system. "Since the reasonable cost of the services would be covered, hospitals would not be deterred, because of nonpaying or underpaying patients in this aged group, from trying to provide the best of modern care." S. Rep. No. 404, 89th Cong., 1st Sess. 27 (1965), reprinted in 1965 U.S.C.C.A.N. 1943, 1967-68. "The provision of insurance against the covered costs would encourage participating institutions, agencies, and individuals to make the best of modern medicine more readily available to the aged." S. Rep. No. 404, 89th Cong., 1st Sess. at 24, 1965 U.S.C.C.A.N. at 1965.

Deeming dual eligibles and QMBs to be primarily Medicaid rather than Medicare patients prevents health care providers from collecting their reasonable costs or charges. Providers will consequently refrain from treating the most vulnerable of the elderly and disabled, those who are also poor. These groups are the true subjects of this appeal, and such a result is fundamentally at odds with Congress' vision in enacting the Medicare Act.

The buy-in provisions of Medicaid

The statutory section that specifies cost-sharing obligations for buy-ins is 42 U.S.C. § 1396a(a). It mandates that "[a] State plan for medical assistance [Medicaid] must . . . . provide," id. at § 1396a(a)(10), "for making medical assistance [Medicaid] available for medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in

section 1396d(p)(1) . . . ." Id. at § 1396a(a)(10)(E). Cost-sharing is defined as Part B premiums, deductibles and the difference between the amount paid by Medicare (80%) and "the amount that would be paid under such section if any reference to '80 percent' therein were deemed a reference to '100 percent' [i.e., 20%]." 42 U.S.C. § 1396d(p)(3). The apparent meaning of this section is that the states that participate in Medicaid must allocate Medicaid funds to the enrollment of all dual eligibles and QMBs in Part B of Medicare and to the payment of 20% of reasonable costs or charges along with the annual deductibles incurred in this program.

Appellees claim that 42 U.S.C. § 1396a(a)(10)(E), quoted above, requires only that a state make Medicaid funds available (to pay cost-sharing amounts for buy-ins) up to the Medicaid rates. Appellees base this claim in part on Congress' simultaneous enactment in 1986 of § 1396a(a)(10)(E) and 42 U.S.C. § 1396a(n). The latter provision *permits* state reimbursement of cost-sharing amounts to QMBs to exceed the Medicaid rates. According to appellees, Congress would not simultaneously require (under (a)(10)(e)) and permit (under a(n)) the same result.

Although the argument has a surface appeal, upon analysis it is not persuasive. A statute requiring Medicaid funds to be made available for Medicare cost-sharing can only sensibly be read as requiring the funds to be made available to cover *all* Medicare cost-sharing. It is counter-intuitive that a statute requiring Medicaid funds to be made available for cost-sharing only to the extent of the Medicaid scheduled rates would not specify that qualification expressly. Furthermore, it appears that the reason that section a(n) authorizes payment beyond the Medicaid amount, when it is required by another section, is to clar-

ify that the Medicaid Act[3] does not prohibit a provider from accepting more than the Medicaid rate. To ensure that it be understood that providers of care to dual eligibles and QMBs are allowed and entitled to accept the state's full cost-sharing reimbursement, which (a)(10)(E) now mandates, a(n) gives providers this explicit authorization. As we hold today, a Medicare provider need not be satisfied with inadequate payment, i.e., less than reasonable costs or charges, even when that provider is treating a Medicare patient who happens also to be poor.

Predecessor to § 1396a(a)(10)(E)

To support their position that the Regulation is not contrary to the Medicare and Medicaid Acts, appellees rely on, among other things: a predecessor section to (a)(10)(E); a district court decision construing that earlier section; and legislative history. Before 42 U.S.C. § 1396a(a)(10)(E) was enacted, 42 U.S.C. § 1396a(a)(15) of the Medicaid Act governed a state's obligations to pay cost-sharing amounts for patients enrolled in Part B of Medicare under a buy-in arrangement. Although (a)(15) has been repealed, effective July 1, 1989, both parties in this case discuss it extensively. The district court's original judgment was addressed to the Secretary's interpretation of (a)(15) but this earlier judgment was vacated and the court later took into account the new (a)(10)(E) in rendering its final judgment. We shall analyze section (a)(15) for the guidance it provides in understanding the section that replaced it.

Prior to its repeal, (a)(15) required that a state Medicaid plan "provide where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to

3 Specifically, 42 U.S.C. §§ 1320a-7b(d), formerly § 1396h(d), as elaborated by 42 C.F.R. § 447.15 (1989).

such individual [covered by Part B under a buy-in arrangement] . . . is not met, the portion thereof which is met shall be determined on a basis reasonably related . . . to such individual's income or his income and resources[.]" We understand this section to mean that if the state chooses not to pay the entire cost-sharing amount, the state must pay what remains after patients are allocated that portion of the liability commensurate with their ability to pay. Appellees claim that this section is only a limitation on how much a patient may be charged but not an indication of the minimum required of a state. We disagree. If the only purpose of the section were to put a ceiling on what a buy-in patient could be charged, the section could have stated as much. The significance of the statute as written is to provide two alternatives: either a state pays all cost-sharing amounts, or the state pays all except that portion allocated to the patient based on the patient's income and resources.

This understanding is also consistent with the providers' entitlement under Medicare to receive 100% of their reasonable costs or charges. Whether the state pays these costs or charges in full or whether part is allocated to the patient based on ability to pay, the provider is compensated and is therefore encouraged to continue to treat the poor elderly and disabled. This encouragement serves the goals of the Medicare Act. To the extent that (a)(15) guides our reading of successor section (a)(10)(E), the meaning of (a)(15) is consistent with a requirement for payment of all cost-sharing amounts by the state under (a)(10)(E). At most, (a)(15) might support an argument that (a)(10)(E) incorporated the alternative of allocating a portion of liability to patients based on their ability to pay.

Appellees also rely on Samuel v. California Dep't of Health Services, 570 F. Supp. 566 (N.D. Cal. 1983), to support the validity of the Regulation, at least under the former section (a)(15). In *Samuel*, a California district court upheld a state regulation which, like the Regulation here, limited the state's obligation to pay cost-sharing reimbursement for buy-in dual eligibles on the basis of the state's Medicaid rates. Id. at 574. The court also held that providers may not collect these amounts directly from dual eligibles, under what was formerly Medicaid, 42 U.S.C. § 1396h(d)(1) but has now been recodified as 42 U.S.C. §§ 1320a-7b(d). Id. Appellees assert that, as the court noted in *Samuel*, there was no clear intent in the legislative history of (a)(15) to protect providers by guaranteeing them reimbursement. 570 F. Supp. at 570. We disagree. Moreover, we would include in any examination of legislative history an examination of the history of the Medicare Act, since those individuals covered by Part B under (a)(15) are Medicare patients. As we have already indicated, the Senate Report accompanying the Medicare Act evidenced an intent to provide quality medical care for the elderly by compensating providers reasonably for their care. A guarantee of reimbursement, by protecting providers, protects patients.

Finally, appellees suggest that the "subsequent legislative history" of (a)(15) reveals that (a)(15) permitted the limitation of a state's cost-sharing obligations for dual eligibles on the basis of Medicaid rates. Appellees cite, for example, the House Report on the Medicare Catastrophic Coverage Act of 1988, which noted that "with respect to dual Medicaid-Medicare eligibles, some states pay the coinsurance even if the amount that Medicare pays for the service is higher than the State Medicaid payment rate, while others do not. . . . [I]f a State chooses to

pay some or all of the coinsurance in this circumstance [where the Medicaid rate is lower than what Medicare covers], Federal matching funds would, as under current law, be available for this cost." H.R. Rep. No. 105(II), 100th Cong., 2d Sess. 61 (1988), reprinted in 1988 U.S.C.C.A.N. 857, 884. Appellees also cite the legislative history of the Omnibus Budget Reconciliation Act of 1989, in which Congress recognized that most states limit reimbursement for dual eligibles to the Medicaid rate. H.R. Rep. No. 247, 101st Cong., 1st Sess. 364 (1989), reprinted in 1989 U.S.C.C.A.N. 1906, 2089-90.

As appellants rightly contend, the Committee reports cited, written more than 20 years after enactment of the Medicare and Medicaid Acts, do not mention or purport to construe (a)(15). They merely refer to what the Committee understood to be the *practice* of some states concerning payment of cost-sharing amounts. Furthermore, even when a subsequent House Committee has actually commented upon an earlier statute, the interpretation carries little weight with the courts. See Oscar Mayer & Co. v. Evans, 441 U.S. 750, 758 (1979); Pierce v. Underwood, 487 U.S. 552, 566 (1988); United States v. Price, 361 U.S. 304, 313 (1960). We accordingly refuse to read the subsequent legislative history which appellant cites as evidence that the Regulation is valid, under either the former (a)(15) or the current (a)(10)(E).

Inconsistency of the Secretary's policy

As we stated above, where—as here—an issue is a question of law involving statutory construction and analysis of Congressional intent, and the meaning of the statute is clear, an agency interpretation is entitled to less deference. INS v. Cardoza-Fonseca, 480 U.S. 421, 446-48 (1987); Chevron, 467 U.S. at 843 n.9; International

Union, United Automobile, Aerospace and Agricultural Implement Workers of America v. Brock, 816 F.2d 761, 764 (D.C. Cir. 1987). But even where a statute is ambiguous or silent on a particular question—as we do not believe the Medicare and Medicaid statutes are with respect to the question before us—where the Secretary's policy is inconsistent with an earlier policy, that inconsistency is a ground for rejecting a claim for deference. In *Cardoza-Fonseca*, for example, the Supreme Court stated that "[a]n agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held agency view." 480 U.S. at 446 n.30 (citations omitted). In Samaritan Health Service v. Bowen, the Court of Appeals for the D.C. Circuit struck down as unreasonable the Secretary's interpretation of a provision of Medicare, an interpretation that had led to the denial of Medicare reimbursement claims. The court stated in its opinion that "[a]ny deference that an interpretive rule may claim depends on [among other things] . . . 'its consistency with earlier and later pronouncements . . .' ". 811 F.2d 1524, 1529 (D.C. Cir. 1987), citing Skidmore v. Swift & Co., 323 U.S. 134, 140 (1944). The expertise in statutory interpretation to which we normally defer becomes dubious when the expert cannot make up its own mind.

This case presents an example of such inconsistency. Although appellees assert that the Secretary's approval of the Regulation accords with his longstanding policy, this assertion is not entirely accurate. In a 1981 policy memorandum, the Secretary announced that with respect to dual eligibles who have buy-in Medicare coverage, "if the MediCal [Medicaid] agency has made no payment at all, the physician/supplier may collect coinsurance [i.e. 20%

of reasonable charges] and deductibles from the MediCal [Medicaid] eligible patient." Department of Health & Human Services Memorandum, September 29, 1981 (emphasis added). As we stated above, under the New York Regulation, the providers for most dual eligibles and QMBs who have buy-in Part B coverage will receive nothing from Medicaid because the 80% which Medicare pays will exceed the Medicaid rate. Therefore, the providers for these buy-in patients would have been authorized, under the Secretary's 1981 policy, to collect coinsurance from their patients directly. In *Samuel*, the California district court case we discussed above, the Secretary urged this position with the State of California:

> Suppose, however, the doctor chooses not to bill MediCal [Medicaid] but only Medicare. In that case the doctor, depending on his conscience, may take his 80% reimbursement from Medicare and bill the beneficiary the remaining 20%. Note that this is totally outside the State plan and beyond the reach of any proscriptions which might be imposed under the Medicaid Act; whether the doctor bills the patient in the Medicare-only situation is a matter between the doctor and his patient. The State cannot control physicians and cannot stop them from billing certain *charges permitted by the federal government.* (emphasis added)

Similarly, the Secretary there asserted:

> What the plaintiffs are really complaining about is the practice of some doctors in charging co-payments to their patients. *Congress has seen fit to allow the doctors discretion to impose such charges and if plaintiffs are unhappy about it their remedy is to seek corrective legislation.* (emphasis added)

Thus, in 1981 the Secretary presumed that providers have the right to receive 100% of their reasonable costs or charges for services to patients enrolled in Part B Medicare pursuant to a buy-in arrangement, a right that providers could assert even against indigent, Medicaid-eligible patients. The Secretary did not consider such patients to be "primarily Medicaid" in 1981. We reject the Secretary's reading of the statutes to suggest that these patients are "primarily Medicaid" in 1991.[4]

IV. Conclusion

When faced with a complicated statutory scheme, there is a strong temptation for judges to assume that the scheme has no fixed meaning or purpose and simply to defer to the interpretation given the statutory text by an administrative agency. In a society as complex as ours, many statutes are of necessity complicated. However, complexity is not the same as ambiguity. Congress passes legislation with specific purposes in mind. When the ordinary tools of statutory construction permit us to do so, we must attempt to discover those purposes from the text,

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4 It is true that in Chevron, the Federal Agency at issue—the E.P.A.—had adopted different policies with respect to the definition of "stationary source" under the Clean Air Act from one administration to the next. See Chevron, 467 U.S. at 863-64. However, these policies were both within the policy-making authority implicitly delegated by Congress to the agency in flexibly implementing its statute. In our case, by contrast, the position that Medicare providers are entitled to collect their fees from dual eligibles (the Secretary's position in 1981) is absolutely at odds with the position that the providers are bound to accept only the Medicaid scheduled amount for dual eligibles (the Secretary's position in 1991). Congress intended either that buy-in patients be responsible for cost-sharing or that they not be responsible for cost-sharing. The Secretary changed policies not because he found that one of two permissible policies was more desirable in implementing the unspoken intent of Congress. The Secretary changed because, as he submits in his brief, he now believes that the previous policy was in error.

structure and history of the acts in question. Sometimes we will find that Congress has not addressed the problem posed by a particular case. In such circumstances, we are required to defer to administrative expertise. But where we confront a statute that evinces a legislative purpose clearly at odds with the proffered administrative interpretation, we should not defer. Indeed, our constitutional duty to interpret the law requires us to effectuate the legislative intent notwithstanding the contrary administrative view.

We have considered all of appellees' arguments and, for the reasons set forth above, we reverse the judgment of the district court and remand with directions to grant summary judgment to appellants.

CARDAMONE, *Circuit Judge*, dissenting:

I respectfully dissent from my colleagues' conclusion that the views of the state and federal administrative officers, appellees here, are at odds with the thrust of the legislative purpose. In a climate of budgetary constraint, appellee Commissioner Perales of New York promulgated a regulation, which was approved by appellee Secretary Sullivan of the U.S. Department of Health and Human Services, that saves public money in the delivery of medical care. My colleagues find the regulation at issue contrary to both the Medicare and Medicaid Acts facially and when viewed in light of legislative history. They also believe the Secretary's policy in this area has been inconsistent and is therefore entitled to little or no deference. It is my belief that appellees each acted well within their

discretionary authority and consistent with legislative aims.

The thrust of appellants' argument is that New York's 18 NYCRR § 360.10 fails to satisfy the reimbursement requirements of the Medicare Act. The Secretary, on the other hand, has determined that crossovers and QMBs are "primarily Medicaid patients," and accordingly §360.10 need satisfy only the lesser reimbursement requirements of the Medicaid Act. The majority has adopted appellants' position as their premise, that is, crossovers and QMBs are for all purposes Medicare beneficiaries. It is conceded that were crossovers and QMBs to be classified for all purposes as *Medicare* beneficiaries, § 360.10 would violate the Medicare Act because it operates to preclude service providers treating such dual eligibles from collecting 100 percent of their reasonable costs or charges. But since whether dual eligibles should be classified for all purposes as Medicare beneficiaries is the precise question we have been called upon to decide, it is inappropriate to adopt appellants' view as a premise. Before analyzing the manner in which § 360.10 affects reimbursement of providers treating crossovers or QMBs, it must first be determined whether that effect should be analyzed under the Medicare Act or the Medicaid Act.

A. *Deference to Administrative Agency Generally*

It has long been recognized that it is inappropriate for courts to resolve competing legislative policy objectives and that latitude must therefore be accorded an agency's determination of how best to exercise the authority delegated to it. *See, e.g., Chevron USA Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843 (1984) (quoting *Morton v. Ruiz*, 415 U.S. 199, 231

(1974)); *United States v. Shimer*, 367 U.S. 374, 383 (1961). In the instant case the majority's statement that "there is nowhere articulated in the Medicare Act or regulations an exception for dual eligibles or QMBs or any limitation on providers' express statutory right to recover their full reasonable costs or charges" effectively places the burden on the Secretary to identify an express delegation of authority. This view ignores the well-settled standard for determining when authority has been delegated to an agency. The test is not whether the Medicare Act explicitly allows crossovers and QMBs to be classified for purposes of *Part B* service provider reimbursement as primarily Medicaid recipients. Rather, the appropriate inquiry is whether there is anything in the statutes or the legislative history clearly evincing a contrary congressional purpose. *See United States v. Fulton*, 475 U.S. 657, 666 (1986) (reasonable agency interpretation of statute to be upheld absent "definitive contrary legislative command"); *Chevron*, 467 U.S. at 843 (court may not impose its own construction of statute in place of agency's if "*Congress has not directly addressed the precise question at issue*") (emphasis added); *accord Weeks v. Quinlan*, 838 F.2d 41, 44 (2d Cir. 1988).

My colleagues' approach on this point overlooks the fact that a delegation of agency authority may be implicit rather than explicit. *Chevron*, 467 U.S. at 844. Consequently, "if the statute is *silent or ambiguous with respect to the specific issue*," deference is warranted. *Id.* at 843 (emphasis added); *see also Fulton*, 475 U.S. at 666-67 (statute addressing "rate[s]" did not specifically address interim rates, thus deference to agency warranted). Nothing in the language of these Acts itself fairly supports an inference that Congress *specifically* intended crossover and QMB *Part B* service providers to be reimbursed at the

Medicare reasonable cost/charge level. In fact, the majority's efforts to construe ambiguous and conflicting provisions of the Medicare and Medicaid Acts as precluding limiting crossover and QMB Part B service provider reimbursement to Medicaid levels demonstrate this. The majority's interpretation of these Acts simply does not lay out a "clear" *plan of Congress* contrary to the Secretary's construction of the same statutes.

B. *Legislative History*

Appellants rely on legislative history that they contend demonstrates Congress' purpose to classify similarly all Medicare beneficiaries. Citing legislative history, the majority suggests that Congress wanted to avoid a "wealth-based, two-tiered system of health care" for those eligible for Medicare. The cited legislative history addresses only Medicare *Part A*. The relevant portion of the Senate report is as follows:

A. HEALTH CARE

***

> The first of the two insurance programs [*i.e.*, Medicare Part A] consists of protection against the costs of hospital and related care . . . .
>
> ***
>
> The second of the two insurance programs [*i.e.*, Medicare Part B] is a *voluntary supplementary medical insurance plan* that would cover a substantial part of the cost of physicians' services and a number of other health items and services not covered under the hospital insurance program . . . . The combined coverage of the two insurance plans would result in

protection for the elderly of a quality that only a few older people can now afford. Most elderly people can be expected to have the protection of both of these insurance programs.

The provision of insurance [*i.e.*, Part A and Part B] against the covered costs would encourage participating institutions, agencies, and individuals to make the best of modern medicine more readily available to the aged.

***

1. BASIC PLAN—HOSPITAL INSURANCE

***

(b) Benefits

***

(1) Inpatient hospital benefits

***

Covered Services.—The reasonable cost of service ordinarily provided to inpatients by hospitals . . . would be paid for . . . . Since the reasonable cost of the services would be covered, hospitals would not be deterred, because of nonpaying or underpaying patients in this aged group, from trying to provide the best of modern care . . .

***

Payments would not be made under the hospital insurance plan for the services of physicians . . .

***

2. VOLUNTARY SUPPLEMENTARY PLAN

***

(b) Benefits under the voluntary supplementary plan

The voluntary supplementary plan would provide protection that *builds upon the protection provided by the hospital insurance plan.* It would cover physicians' services, additional home health visits, and a variety of other health services, not covered under the hospital insurance plan. The beneficiary would pay the first $50 of expenses he incurs each year for services of the type covered under the plan. Above this deductible amount, the plan would pay 80 percent of the reasonable costs in the case of services provided by an institution or home health agency and 80 percent of reasonable charges for other covered services, with normally 20 percent being paid by the beneficiary.

***

(c) Method of payment under the voluntary supplementary plan

***

. . . In general, under the supplementary plan a provider of services . . . could charge a beneficiary the $50 deductible and 20 percent of the reasonable charges (in excess of the $50 deductible) for the covered services.

***

5. ACTUARIAL COST ESTIMATES FOR THE VOLUNTARY SUPPLEMENTARY MEDICAL INSURANCE SYSTEM

***

(b) Financing policy

(1) Self-supporting nature of system

The committee has recommended the establishment of a supplementary medical insurance program that can be voluntarily elected, on an individual basis, by virtually all persons aged 65 and over . . . *This program is intended to be completely self-supporting from the contributions of covered individuals and from the equal-matching contributions from the general fund of the Treasury* . . . .

***

S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S. Code & Cong. Admin. News 1943, 1964-2011 (emphasis added).

Reading this Senate Report it is difficult to accept the majority's implicit assertion that the legislative history "clearly" shows Congress aimed for crossover and QMB *Part B* service providers to be reimbursed by the state at the Medicare reasonable cost/charge level. Quite the contrary, to the extent that Congress desired to ensure reasonable cost/charge reimbursement in order to encourage "the best of modern care," such concern seems to have been directed to the Part A program. This is understandable. As the legislative history indicates, Congress distinguished between the services covered under Part A and Part B, probably based on the varying "medical necessity" of the services covered. *Compare id.* at 1966-69, *with id.* at 1982-83; *see also id.* at 2019-20; *cf. Schweiker v. Hogan*, 457 U.S. 569, 590 (1982) (public assistance programs often cannot provide everyone with meaningful benefits in equal measure). From this distinction it follows that the legislature's desire to ensure reasonable cost/charge reimbursement in order to encourage the best of medical care as to Part A services does not control in

the context of the "less medically necessary" services covered in Part B. Moreover, the legislative history demonstrates that in discussing the Part B program Congress envisioned coinsurance, deductible and premium payments would be made by the beneficiary. In light of the fact that crossovers and QMBs cannot pay such charges, it is disingenuous to suggest that in discussing full reasonable cost/charge reimbursement for Part B service providers Congress had within its contemplation crossovers and QMBs. *See Chevron*, 467 U.S. at 862.

The dichotomy between the Part A and Part B programs with respect to dual eligibles is also logical in light of the programs' differing qualification requirements. A Medicare beneficiary—either pure or dual eligible—is automatically entitled to Part A services. Consequently, classifying dual eligibles differently than pure Medicare beneficiaries with respect to Part A services would be arbitrary, insofar as their status as dual eligibles is irrelevant with respect to their entitlement to such services. But neither pure nor dual eligible Medicare beneficiaries are automatically entitled to Part B services. A pure Medicare beneficiary is entitled to Part B services because he or she pays the enrollment premiums; a dual eligible is entitled to such services because—by virtue of his or her status as a Medicaid recipient—the state pays the enrollment premiums. Thus, there is a difference between pure and dual eligible Medicare beneficiaries in respect to Part B services. *See Schweiker*, 457 U.S. at 588 (inconsistent to require comparable treatment among two groups participating in a program when one group may be excluded entirely from participation).

The majority's concern that crossovers and QMBs not be deprived of important medical care is misplaced. First,

it does not follow that because crossover and QMB Part B service providers are reimbursed at the Medicaid rather than the Medicare rate there will be inadequate financial incentive to provide such care. Although admittedly with less incentive fewer providers will offer such care, that is not the crucial question. What is critical is whether reimbursement at the Medicaid level is so low that an "insufficient" number of providers will have a financial incentive to provide services. *See* 42 C.F.R. § 447.204. Nothing in the record supports such a dire conclusion. *See Samuel v. Cal. Dep't of Health Servs.*, 570 F. Supp. 566, 573-74 (N.D. Cal. 1983); *see also Mass. Medical Soc'y v. Dukakis*, 815 F.2d 790, 794-95 (1st Cir.), *cert. denied*, 484 U.S. 896 (1987) (upholding state statute forbidding doctors to bill Medicare patients for fees beyond those reimbursed by Medicare against challenge based on theory that doctors might find Medicare "reasonable" charge unreasonably low, thereby refusing to treat Medicare patients). Moreover, the disincentive theory seems intuitively untenable since, were it true, no doctors or hospitals would ever treat Medicaid patients.

Second, as a result of the majority's holding, it appears if it cannot afford to provide reimbursement up to the Medicare level, New York now has the following three options: (1) permit service providers to bill crossovers and QMBs directly for the coinsurance and deductible amounts—as with pure Medicare beneficiaries. But because, unlike pure Medicare beneficiaries, crossovers and QMBs are by definition unable to pay even the Part B enrollment premiums on their own, this option will not "help" these beneficiaries; (2) discontinue its payment of Part B enrollment premiums for crossovers and QMBs. This option also will not help to ensure that these individuals receive the "best of medical care;" or (3) simply

terminate enrollment in the Part B program for dual eligibles and provide the same services for them directly under the umbrella of the Medicaid program. *See Samuel*, 570 F. Supp. at 573. In that case those providing the services would be reimbursed only at the Medicaid rate and the recipients would receive precisely the same care as presently. Thus, it appears that in focusing on the fact that the services at issue are nominally part of the Medicare program--rather than recognizing that the beneficiaries actually receive these services through the Medicaid program—the majority has elevated judicial form over the substance of what the State of New York is doing and continues to have the option to do.

Further, in relying on the legislative history, my colleagues fail to cite provisions of the 1965 Senate Report that support the proposition that Congress did not aim to *require* crossover and QMB Part B service providers be reimbursed by the state at the Medicare rate. In discussing the Medicaid Act, the report states:

> No deduction, cost sharing or similar charge may be imposed with respect to inpatient hospital services furnished under the plan. This provision is related to another provision in the bill which *requires States to pay* reasonable costs *for inpatient hospital services* provided under the plan. Taken together, these provisions give assurance that the hospital bill incurred by a needy individual [*i.e.*, Medicaid recipient] *shall be paid in full* under the provisions of the State plan . . . and that the States may not expect to require the individual to use his income or resources . . . toward that bill . . . .
>
> For any other items of medical assistance furnished under the plan, a charge of any kind *may* be imposed

only if the State so chooses, and the charge must be reasonably related to the recipient's income or his income and resources. The same limitations apply in the case of any enrollment fee, premium, or similar charge imposed with respect to inpatient hospital services . . . .

The hospital insurance benefit program included under other provisions of the bill [*i.e.*, Medicare Part A] provides for a deductible which *must be paid* in connection with the individual's claim for hospitalization benefits. The committee is concerned that *hospitalization be readily available* to needy persons and that the necessity of their paying deductibles or cost sharing shall not be a hardship on them or a *factor which may prevent their receiving the hospitalization they need. For this reason*, the committee's bill provides that *the State make provisions*, for individuals 65 years or older who are included in the [Medicaid] plan [*i.e.*, crossovers], of the cost of any deductible or cost sharing imposed with respect to individuals under the program established by the hospital insurance [*i.e.*, Part A] provisions of the bill.

A State medical assistance plan may provide for the payment in full of any deductibles or cost sharing under the insurance program established by Part B of title XVIII. In the event, however, the State plan provides for the individual to assume a portion of such costs, such portion shall be determined on a basis reasonably related to the individual's income, or income and resources . . .

S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S. Code & Cong. Admin. News 1943, 2019-20 (emphasis added).

Consequently, while the legislative history cited by the majority may suggest that Congress did not distinguish between pure and dual eligible Medicare beneficiaries in order to assure equal care, when read in its entirety this same history equally demonstrates Congress' purpose was limited at most to Part A services. In fact, while explicitly commanding states to pay dual eligibles' Part A cost sharing and deductible amounts (and providing its reasons for this direction), the Senate Report contains no comparable direction with respect to Part B charges, though states were free not to impose such charges on the recipient. Therefore, it seems incorrect to state that the statutes or their legislative history "clearly" or "demonstrably" indicate a specific congressional aim contrary to the Secretary's interpretation on the issue presented—whether crossover and QMB *Part B* service providers must be reimbursed by the state at the Medicare reasonable cost/charge level.

C. *Secretary's View*

The majority further states that "where the Secretary's policy is inconsistent with an earlier policy, that inconsistency is a ground for rejecting a claim for deference." Again, this formulation of the relevant inquiry seems to me to miss the point. That an agency has changed its interpretation of the statute it is charged with administering is itself not dispositive on the question of whether deference should be accorded the new interpretation. *See, e.g., Chevron*, 467 U.S. at 863-64. What is more important is whether the agency's change in position rests on a "well-considered basis." *See Robertson v. Methow Valley Citizens Council*, 490 U.S. 332, 355-56 (1989). In the instant case, the Secretary having been advised by the

District Court for the Northern District of California in *Samuel* that he erroneously discerned Congress' purpose provides powerful support for concluding that the Secretary's changed interpretation is well-considered. It is ironic that today's holding tells the Secretary he must forbid in New York what he has previously been ordered to permit in California.

D. *Reasonableness*

Once it is determined that the Secretary's interpretation of the statute he is charged with administering is entitled to deference because of an implicit delegation of authority, judicial review is limited to asking whether that interpretation is "reasonable" or "permissible." *See, e.g., Clarke v. Securities Indus. Ass'n*, 479 U.S., 388, 403-04 (1987); *Weeks*, 838 F.2d at 44. Because we need only ask whether the Secretary's interpretation is a reasonable or permissible construction of the statute, the fact that the Secretary's interpretation leads to "some oddities" or is in some respects "counter-intuitive" is not grounds for failing to accord it deference. *See, e.g., Chevron*, 467 U.S. at 843 n.11. Moreover, the reasonableness of the Secretary's interpretation should be analyzed in light not only of the purposes underlying the Medicare Act, but also with regard to the purposes underlying the Medicaid Act. *See N.Y. State Dep't of Social Servs. v. Bowen*, 846 F.2d 129, 133 (2d Cir. 1988).

Medicaid is a joint state-federal program under which states choosing to participate receive federal funding to help subsidize the states' costs in providing Medicaid services. *Harris v. McRae*, 448 U.S. 297, 301 (1980). Reimbursement under Medicaid need not amount to the providers' Medicare-level reasonable cost/charge. *See*,

e.g., 42 U.S.C. § 1320a-7b(d); 42 C.F.R. § 447.15. Rather, in part due to both the states' and the federal government's interest in containing Medicaid costs, *see*, *Schweiker*, 457 U.S. at 590; *State of N.Y. by Perales v. Bowen*, 811 F.2d 776, 779 (2d Cir. 1987), state funding determinations need only accord with "reasonable standards . . . for determining . . . the extent of medical assistance under [its] plan which . . . are consistent with the objectives" of Medicaid. *Harris*, 448 U.S. at 302 (quoting 42 U.S.C. § 1396a(a)(17)); *see also State of N.Y. by Perales v. Sullivan*, 894 F.2d 20, 22 (2d Cir. 1990); 42 U.S.C. §§ 1396a(a)(13)(A), 1396a(a)(30). That general objective is "*as far as practicable*, to furnish medical assistance to individuals whose income and resources are insufficient to meet the costs of necessary medical services." *Beal v. Doe*, 432 U.S. 438, 444 (1977) (emphasis added); *see also Alexander v. Choate*, 469 U.S. 287, 303 (1985) (Medicaid provides a particular package of health services; package has general aim of assuring individuals receive necessary medical care, but the benefit provided remains individual services offered—not "adequate health care").

Thus, because of the purpose of Medicaid and its structure as a cooperative federal and state endeavor, *Harris*, 448 U.S. at 308, it has long been accepted that states have substantial discretion in determining the amount and scope of services to provide. *E.g.*, *Schweiker*, 457 U.S. at 589-91; *Alexander*, 469 U.S. at 303. Necessarily, this discretion allows the states latitude to balance medical and economic concerns in light of that state's particular circumstances in establishing Medicaid rates. *See State of Wis. Dep't of Health v. Bowen*, 797 F.2d 391, 397 (7th Cir. 1986), *cert. dismissed*, 485 U.S. 1017 (1988); *State of N.Y. by Perales*, 894 F.2d at 24; *Miss. Hosp. Ass'n, Inc. v.*

Heckler, 701 F.2d 511, 515 (5th Cir. 1983); *see also Mass. Medical Soc'y*, 815 F.2d at 795.

In this case, the Secretary was called upon to resolve the competing policy concerns expressed in the Medicare and Medicaid Acts and determine the extent to which allowing the state to limit crossover and QMB Part B service providers to Medicaid-level reimbursement impacts upon the availability of such services for those individuals in that state in light of that state's fiscal condition. It is not up to the majority to substitute its view for the Secretary's as to how best to accommodate these concerns. *E.g.*, *Shimer*, 367 U.S. at 383, 385; *Chevron*, 467 U.S. at 864-66.

In my view there simply are no compelling indications that appellees' view is wrong. Hence, I vote to affirm the district court's grant of summary judgment in their favor.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

FILED MARCH 13, 1991

87 CIV. 4896 (MJL)

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, MEDICAL SOCIETY OF THE STATE OF NEW YORK, SIDNEY FINKEL, and JOHN A. BLESKI,

Plaintiffs,

—against—

CESAR A. PERALES, as Commissioner of Social Services of the State of New York and OTIS R. BOWEN, as Secretary of the United States Department of Health and Human Services,

Defendants.

OPINION AND ORDER

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MARY JOHNSON LOWE, *D.J.*

Before this Court is plaintiffs' motion pursuant to Fed.R.Civ.P. 56 for summary judgment on Counts I through III of their Complaint. Defendant Otis R. Bown ("Bowen" or the "Secretary"), Secretary of the United States Department of

Health and Human Services, cross-moves for summary judgment on these counts. Defendant Cesar A. Perales ("Perales"), Commissioner of Social Services of the State of New York, also cross-moves under Fed.R.Civ.P. 12(b)(6). For the reasons stated below, defendants' motions are granted and plaintiffs' motion is denied.

BACKGROUND

This action challenges an amendment to a New York State Regulation which, according to plaintiffs, would either reduce or eliminate entirely their federal statutory right to receive certain payments for health care services rendered by them to persons who are eligible for benefits under both the Medicare and Medicaid Programs. Because the issues raised here involve interpretation of a Congressional act whose construction has been characterized as "Byzantine,"[1] we take some pains to set out the relevant portions of the statutory scheme.

The Medicare Program

Congress established the Medicare Program in 1965 as Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395zz. The Medicare program is a purely federal one and provides reimbursement for medical care to the aged and to certain disabled persons under 65 years of age. Part B of the Medicare Program, with which this litigation is concerned, is a voluntary supplementary program for Medicare-eligibles who choose to enroll. It pays for certain physician services, hospital outpatient services, and other health services generally not covered under Part A of the program.

The Part B Medicare Program is financed both through premium payments made by the beneficiary and through contri-

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1 To quote in full:

> "The Social Security Act is among the most intricate ever drafted by Congress. Its Byzantine construction, as Judge Friendly has observed, makes the Act 'almost unintelligible to the initiated.' "

Schweiker v. Gray Panthers, 453 U.S. 34, 43 (1981) (quoting *Friedman v. Berger*, 547 F.2d 724, 727, n.7 (2d Cir. 1976), *cert. denied*, 430 U.S. 984 (1977)).

butions from the federal government. The beneficiary is also required to pay an annual deductible. Above that deductible amount, Medicare pays 80% of the "reasonable costs" of hospital services, and 80% of the "reasonable charges" of physicians' services.[2] The beneficiary remains responsible for the 20% coinsurance amount.

The Medicaid Program

In 1965, Congress also enacted the Medicaid Program as Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* This program was designed to reimburse certain medical costs for needy persons. The Medicaid Program is a cooperative one, funded by both the federal and state governments. States choosing to participate in it, however, must have their medical assistance plan approved by the Secretary of the United States Department of Health and Human Services (the "Secretary").

Payments under the Medicaid Program are generally not based upon "reasonable costs" or "reasonable charges"; indeed, they are generally lower.[3] Moreover, federal regulations mandate that the state plan require the designated state agency[4] to limit participation in the Medicaid program to providers who accept, as payment in full, the amount paid for the medical services by the Medicaid program. 42 C.F.R. § 447.15.

The Buy-In Agreement and The Instant Controversy

Under the Medicare statute, 42 U.S.C. § 1395v, a state may enter into an agreement with the Secretary by which it enrolls Medicaid recipients who are also eligible for Medicare

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2 Those costs and charges are calculated pursuant to the Medicare Act and Regulations.

3 Plaintiffs argue that New York state has established Medicaid reimbursement rates that are in all cases lower than "reasonable cost" or "reasonable charges" established by Medicare Part B for the same services, and which, in almost all cases, are lower than 80% of such "reasonable costs" or "reasonable charges." *See Plaintiffs' Memorandum of Law in Support of Summary Judgment at 9.*

4 In the instant case, the designated state agency is the Department of Social Services of the State of New York (the "Department").

("crossovers" or "dual eligibles") in the voluntary Medicare Part B program. Under this agreement, the state, rather than the beneficiary, pays the Medicare premiums.

New York state has entered into such a buy-in agreement. In addition to paying the premiums under this arrangment, New York also paid, up until January 1, 1987, the full cost-sharing amounts on behalf of its crossover beneficiaries—*i.e.* the Medicare deductibles and the 20% coinsurance amounts.

On March 16, 1988, however, the Secretary approved a proposed amendment to the New York state plan governing payments under New York's buy-in agreement. That amendment, 18 New York Code of Rules and Regulations ("NYCRR") 360.10,[5] which became retroactively effective on January 1, 1987, provides that the State's Medicaid agency will pay Medicare co-insurance and deductible amounts for crossovers only up to the approved Medicaid rate. The amendment also prohibits providers agreeing to treat crossovers from seeking to recover, from the patients themselves, any of the Medicare coinsurance or deductible amounts.[6] In short, the amendment

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5 Since the commencement of this litigation, § 360.10 has been repealed and recodified as 18 N.Y.C.R.R. § 360-7.7, effective March 1, 1989. However, for the purpose of consistency with the papers submitted by the parties, the regulation is referred to in this Order by its original number, 360.10.

6 Section 360.10 reads in part:

. . . (b) Medical assistance (*i.e.*. Medicaid payments) shall include the amount of any deductible or coinsurance liabilities under Medicare Part B for all eligible applicants or recipients to the extent that:

(1) When the Medicare payment to a provider of a Part B benefit is less than the established medical assistance fee or rate for the benefit, the Department shall pay the provider an amount equal to the difference between the Medicare Part B payment and the lower of:

(i) the established medical assistance fee or rate; or
(ii) the Medicare approved amount.

(2) When the Medicare payment to a provider of a Part B benefit equals or exceeds the established medical assistance fee or rate for the benefit, the Department shall pay no Part B coinsurance or deductible amounts to the provider. . .

(d) Providers of care, services, supplies or equipment covered under Medicare Part B and the medical assistance program shall accept assignment of a person's right to receive Medicare Part B payments and shall not seek to recover Medicare Part B deductible or coinsurance amounts from such person if such person is also eligible for medical assistance.

requires the provider to essentially treat the crossover patient as a Medicaid recipient and to accept, as payment in full for his Medicare services, an amount no greater than the Medicaid-approved rate.[7]

On July 10, 1987, plaintiffs—all of whom are health care providers[8]—filed the instant action challenging § 360.10. Specifically, plaintiffs contend that § 360.10: 1) deprives providers, such as themselves, of their claimed statutory right to reimbursement of their reasonable costs or charges in violation of the *Medicare* Act (Count I); 2) violates the *Medicare*

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7 Operation of the challenged amendment is illustrated below:

1) If the Medicare payment exceeds the Medicaid rate or fee, Medicaid need not pay any additional amount:

Medicaid Fee or Rate = $45

Medicare Approved	*Medicare Paid*	*Balance Due*
$80	(80% of $80) or $64	$0

2) If the Medicare payment is less than the Medicaid rate or fee, Medicaid must pay the difference between the Medicare Paid amount and the lower of the Medicaid fee/ rate or the Medicare approved amount:

Medicaid Fee or Rate = $70

Medicare Approved	*Medicare Paid*	*Balance Due*
$60	(80% of $60) or $48	$12 ($60-$48)

Medicaid Fee or Rate = $50

Medicare Approved	*Medicare Paid*	*Balance Due*
$60	(80% of $60) or $48	$2 ($50-$48)

8 Plaintiff New York City Health and Hospitals Corporation ("HHC") is a New York public benefit corporation and is a principal provider of hospital services, including outpatient hospital services, to the low-income population of New York City who are intended beneficiaries of the Medicaid Act. Complaint at ¶ 6.

Plaintiff Medical Society of the State of New York ("MSSNY") is a domestic non-profit corporation and is the largest voluntary organization of physicians in New York. Many of its members treat crossovers. *Id.* at ¶ 7.

Plaintiff Sidney Finkel, M.D., is a medical doctor who practices in Westbury, Long Island. He is a participating physician in the Medicare program and a provider in the Medicaid program. *Id.* at ¶ 8.

Plaintiff John A. Bleski, M.D., is a medical doctor who practices in Kingston, New York. He is a participating physician in the Medicare program and treats a number of regular patients who are dually eligible under both the Medicare and Medicaid programs. *Id.* at ¶ 9.

Act's prohibition of cost-shifting (Count II); 3) violates specified portions of the *Medicaid* Act's crossover provisions (Count III); and 4) deprives plaintiffs of their property interests in violation of the Due Process Clause of the Fourteenth Amendment (Count IV).[9]

Since the parties first submitted their motions and cross-motions, Congress has twice amended the Medicaid Act in areas relevant to this litigation. Those amendments, and their effect on the instant controversy, are the subject of four letters to this Court and are also taken under consideration here. One such amendment has led plaintiffs to assert a fifth cause of action under the new § 1396(a)(10)(E). However, plaintiffs' Complaint has not been formally amended to state this additional cause of action.[10]

DISCUSSION

Standard of Review

When a court is presented with issues of statutory construction, it must address two essential questions:

> First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court determines that Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, . . . the question for the court is

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9 Plaintiffs contend that "[i]n light of the clear statutory violations [enumerated in Counts I-III], it is not necessary to reach the constitutional claim and that [such claim is therefore] not presented on this motion." Plaintiffs' Memorandum of Law at 16-17.

10 Plaintiffs are hereby directed to formally amend their Complaint, if at all, within thirty days of the date of this Order.

> whether the agency's answer is based on a permissible construction of the statute.

Chevron U.S.A. v. Natural Res. Def. Council, 467 U.S. 837, 842-843 (1983). In upholding an agency's answer, moreover, "[t]he court need not conclude that the agency construction was the only one it permissibly could have adapted to uphold the construction, or even the reading the court would have reached if the question initially had arisen in a judicial proceeding." *Id.* at 843 n.11. Rather, the agency's interpretation is to be given controlling weight unless it is "arbitrary, capricious or manifestly contrary to the statute." *Id.* at 844. With this standard set forth, we now turn to the specific arguments raised by the plaintiffs.

Counts I and II

With respect to Count I of their Complaint, plaintiffs argue that the amended § 360.10 denies them their statutory right, under the Medicare Act, to charge Medicare beneficiaries the remaining cost-sharing amounts and/or to recover their reasonable costs/charges. This right, plaintiffs assert, exists even where the Medicare beneficiary also happens to be eligible under Medicaid.

With respect to Count II, plaintiffs contend that § 360.10 violates the Medicare Act's proscription against cost-shifting, as detailed in 42 U.S.C. § 1395x(v)(1)(A) and 42 C.F.R. § 413.80(d). Section 413.80(d) of title 42 of the Code of Federal Regulations provides:

> Under Medicare, costs of covered services *furnished beneficiaries* are not to be borne by individuals not covered by the Medicare program, and conversely, costs of services provided for other than beneficiaries are not to be borne by the health insurance program. Uncollected revenue related to services rendered to beneficiaries of the program generally means the provider has not recovered the cost of services covered by that revenue. The failure of beneficiaries to pay the deductible and coinsurance amounts can result in the related costs of covered services

> being borne by other than Medicare beneficiaries. (emphasis supplied)

Plaintiffs appear to contend that, by preventing providers from recovering the remaining cost-sharing amounts from either the patient or the state § 360.10 shifts those unpaid costs onto the providers. The unspoken consequence of this scenario is that the providers will either bear the loss or shift the unpaid portions of their costs/charges onto their non-Medicare/Medicaid patients.

We deal with these contentions together because they both rely upon an essential premise: that by purchasing Medicare Part B coverage for its Medicaid recipients, the State has transformed those recipients, for the purpose of provider reimbursement, into Medicare beneficiaries. This premise is integral to plaintiffs' claims because, quite logically, the rights and proscriptions of the Medicare Act upon which they rely apply only to Medicare beneficiaries and their Medicare providers.

Plaintiffs support this premise only cursorily in their Reply Memorandum to this Court in which they state:

> {I}t is clear that the services provided to crossovers are services provided under the *Medicare* program. Payment for such services is {therefore} made, and must be made, pursuant to the Medicare-approved reasonable cost and charges.

Plaintiffs' Reply Memorandum of Law at 9-10 (emphasis in original; footnote omitted). This argument, however, is itself based upon an unsupported premise: that the services a patient receives define that patient's status as a beneficiary and that patient's payment obligations.

In support of its own motion for summary judgment, the Secretary argues that there is nothing in the Medicare Act which makes its reimbursement schedule controlling in the case of a crossover patient. Plantiffs' rebuttal to this—that there is also nothing within the Medicare statute which would preclude application of the Act's policies and proscriptions to crossover patients—does not however, prove plaintiffs' premise. Rather, it merely underscores the absence of any Congressional direc-

tive concerning the treatment of crossovers, one way or the other, for payment purposes. In the absence of any clear Congressional intent on the matter, this Court is therefore relegated to determining whether the Secretary's interpretation of those payment obligations is based upon a permissible construction of the statutes at issue here.

It has been the Secretary's consistent policy, since at least 1971,[11] to treat crossover patients as primarily Medicaid patients. Streimer Affidavit at ¶ 5. In formulating this policy, the Secretary, as well as the state, has taken the position that, with respect to buy-in agreements, Medicare plays the role of a third party payor. Indeed, that position appears to be consistent with the relevant federal implementing regulations and with prior case law on the matter. See 42 C.F.R. § 433.136; *New York State Dept. of Social Services v. Bowen*, 661 F.Supp. 1537, 1551-52 (S.D.N.Y. 1987). It is also a position with which the plaintiffs have no apparent disagreement.[12] Having conceded that point, it is difficult to see how plaintiffs can claim an entitlement to cost-sharing payments directly from the crossovers. After all, the Medicaid Act, 42 U.S.C. § 1396(a)(25)(C), specifically provides that "the person furnishing the service *may not seek to collect from the individual* . . . payment of an amount for that service . . . if the total amount of the liabilities of third parties {*i.e.* Medicare} for that service is at least equal to the amount payable for that service under the {state} plan {*i.e.* Medicaid}." (emphasis supplied).

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11 Policy Information Memorandum No. 6, dated March 4, 1971, states:

> . . . the [state] agency is not necessarily obligated to pay the full amount of the deductibles and coinsurance costs according to the rates established under Title XVIII {Medicare Act}, but only that amount which will satisfy the requirement for payment in full according to the Title XIX {Medicaid Act} method of payment.

Reply Affidavit of Peter F. Nadel, Exhibit C.

12 Rather, plaintiffs argue that these general third party liability provisions cannot be read to implicitly amend 1396(a)(15) which, they contend, imposes upon the state a specific obligation to pay the cost-sharing amounts of crossovers. Plaintiffs' Reply Memorandum at 33-37. We address plaintiffs' arguments with respect to § 1396(a)(15) *infra*.

By forbidding recourse to the beneficiaries, the amendment here challenged merely incorporates this statutory prohibition.

The real target of plaintiffs' claims under the Medicare Act, however, is not the beneficiary, but the state and its Medicaid plan. Plaintiffs' Memorandum at 17. But again, the rules governing payment under third party arrangements do not mandate full payment by the state. Rather, 42 C.F.R. 433.139(b)(1) provides that "[w]hen the amount of [third party] liability is determined, the [state] agency must then pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment." The implicit corollary of this regulation is that the state may, but need not, pay more. Plaintiffs' arguable interpretation of 1396(a)(15) side, moreover, there is nothing in either the Medicare or Medicaid statutes which even remotely suggests that where the state assumes payment of a recipient's Medicare premiums, it also implicitly assumes payment of that beneficiary's cost-sharing amounts.

Plaintiffs' contention that § 360.10 is violative of the Medicare Act's cost-shifting proscription does not stand on firmer ground. Again, plaintiffs make the very sweeping assumption that the policy considerations underlying the Medicare Act are wholly applicable to buy-in agreements. Even if we were prepared to make such an assumption, however, one would necessarily have to hold the additional presupposition that § 395x(v)(1)(A)'s cost-shifting proscription, as plaintiffs characterize it, was intended to protect health care providers and physicians. Yet one need not look beyond the legislative history of that provision and the implementing regulations promulgated thereunder to determine that the intended beneficiaries of this so-called cost-shifting proscription are not health care providers and physicians, but other patients not covered by the Medicare insurance program. While providers and physicians might, as a practical matter, shift those costs onto their non-Medicare patients, that is not an assumption this Court will make in the absence of any evidence or argument by plaintiffs that that is in fact what is occurring. Finally, we note that § 1395x(v) speaks only in terms of "reasonable costs" and can

therefore only be deemed applicable to "providers," not "physicians."[13] With respect to those providers, moreover, 42 C.F.R. § 413.80(a) provides that "bad debts attributable to the unpaid} deductibles and coinsurance amounts are reimbursable under the {Medicare} program." According to the Secretary, such bad debt treatment is available to Medicare providers for their treatment of crossovers. Affidavit of Robert A. Streimer at ¶ 6.[14] Thus, in the face of this regulation, even providers can hardly argue that § 360.10 makes them the victims of cost-shifting.

In upholding the Secretary's interpretation, we do not mean to suggest that plaintiffs' position with respect the buy-in agreements is wholly unsupportable. What plaintiffs fail to come to terms with, however, is that the buy-in agreements reflect a conflation of aspects of two statutes which, in a very fundamental way, are odds with each other. As all parties acknowledge, Medicare is a health insurance program and is intended to be completely self-supporting. On the other hand, Medicaid is a welfare type program intended to provide financial assistance for the medical assistance of needy persons. Under these circumstances, the Secretary's interpretation of the buy-in agreements as third party arrangements represents a permissible construction of the statutes and a reasonable reconciliation of their conflicting nature. It should be noted that, in almost all cases, total reimbursement to providers will be higher than the Medicaid rate of payment and, in some instances, will even be higher than the Medicare rate of payment. *See* Examples, *supra* at 6 n.6.

Count III

Plaintiffs argue that they are entitled to summary on Count III of their complaint, because § 360.10 violates Section

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13 Physicians are reimbursed on the basis of their "reasonable charge{s}." 42 U.S.C. § 13951(a)(1).

14 I.E., although § 360.10 prohibits providers from charging either the patient or the state for unpaid deductibles and coinsurance funds, it does not prevent them from attempting to receive that money from the *federally* funded Medicare program.

1902(a)(15) of the Social Security Act, codified at 42 U.S.C. § 1396a(a)(15), which they argue requires the states to pay cost sharing amounts in full.[15] Section 1396a(a)(15) {hereinafter a-15} 1 reads in relevant part that a Medicaid plan must:

> {I}n the case of eligible individuals 65 Years or older who. . . are covered by either or both of the insurance programs established by subchapter XVIII{Medicare} of this chapter, provide where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to such individual under the insurance program established by such subchapter is not met, the portion thereof which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the the plan) to such individual's income or his income and resources.

Defendants argue that the Secretary has, for a long time, taken the position that a-15 does not require Medicaid to pay Medicare cost-sharing in amounts which would result in providers being reimbursed for a total amount greater than the Medicaid level. Plaintiffs argue that this is an arbitrary and capricious reading of the language. They argue that cost-sharing must be paid in full, by the individual according to his/her income or resources, and the balance by the state.

Defendants point out the fact that a-15 does not explicitly require that providers be paid cost-sharing in full. They argue that *when* a state plan provides for dually eligible individual's to pay a portion of the cost-sharing, that portion must be determined on a basis reasonably related to the *individual's* income and resources. Defendants argue that a-15 was intended, therefore, to protect the interests of the beneficiary, and to insure that already needy beneficiaries are not required to spend, in essence, money that they have already been determined (by

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15 As dicussed on page 8, *supra*, since the commencement of this litigation, § 1396a(a)(15) has been repealed, so discussion of the effect of that section applies only to the situation prior to July 1, 1989, the date on which the repeal became effective.

their eligibility for Medicaid), not to have for medical care. *Defendant Perales' Memorandum of Law in Opposition at 32-35*. Defendants point out that this interpretation of a-15 has been accepted as reasonable in other courts. *See Samuel v. California Department of Health Services*, 570 F.Supp. 566 (N.D.Cal. 1983). The plausibility of defendants' interpretation is somewhat dependent upon the plausibility of their argument that crossover patients are treated by them primarily as Medicaid (and therefore needy), as opposed to Medicare patients. As discussed, *supra*, defendants have demonstrated to this court's satisfaction that that has, indeed, been the Secretary's policy. Again, these regulations are complicated, ambiguous, and often apparently conflicting. Defendants' interpretation of a-15 is a rational interpretation, and while other interpretations may also be rational, it would not be appropriate for this Court to overturn the defendants' rational policy.

Conclusion

Therefore, for the reasons discussed, *supra*, plaintiffs' motion for summary judgment on Counts I-III is denied, and defendants' motions under Fed.R.Civ.Pro.12(b)(6) and 56 are granted.

It Is So Ordered.

UNITED STATES DISTRICT JUDGE

Dated: New York, New York
, 1991

UNITED STATES COURT OF APPEALS
FOR THE
SECOND CIRCUIT

FILED MAY 20, 1992

DOCKET NUMBER: 91-6123

At a stated term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse in the City of New York, on the 20th day of May one thousand nine hundred and ninety-two.

NYC HEALTH & HOSP. V. PERALES ET. AL.

A petition for rehearing containing a suggestion that the action be reheard in banc having been filed herein by Appellee LOUIS W. SULLIVAN

Upon consideration by the panel that decided the appeal, it is

Ordered that said petition for rehearing is DENIED.

It is further noted that the suggestion for rehearing in banc has been transmitted to the judges of the court in regular active service and to any other judge that heard the appeal and that no such judge has requested that a vote be taken thereon.

/s/ ELAINE B. GOLDSMITH
Clerk

RELEVANT STATUTES AND REGULATION

18 N.Y.C.R.R. § 370-7.7

The challenged regulation, codified at 18 N.Y.C.R.R. § 370-7.7, provided as follows:

(a) The MA [Medicaid] program will pay on behalf of MA recipients, including qualified Medicare beneficiaries defined in subdivision (g) of this section, the amount of any deductible or coinsurance liability incurred under Part A of Title XVIII of the Social Security Act.

(b) (1) Except as otherwise provided in paragraph (2) of this subdivision, the MA program will pay on behalf of MA recipients, including qualified Medicare beneficiaries, the amount of any deductible or coinsurance liability incurred under Part B of Title XVIII of the Social Security Act if the Medicare Part B payment is less than the established MA fee. The MA program will pay only the difference between the Medicare Part B payment and the lower of the MA fee or the Medicare approved amount.

(2) The MA program will pay on behalf of MA recipients, including qualified Medicare beneficiaries, the full amount of any deductible or coinsurance liability incurred for ambulance services provided under Part B of Title XVIII of the Social Security Act.

(c) Before the MA program will pay any Medicare Part B deductible or coinsurance liability, the MA recipient or qualified Medicare beneficiary must assign to the provider any Part B benefit payment to which he or she is entitled. A provider of a Medicare Part B benefit must accept assignment from such recipient or beneficiary of his or her right to receive the Medicare Part B payment.

(d) A provider of a Medicare Part B benefit must not seek to recover any Medicare Part B deductible or coinsurance

amounts from an MA recipient or qualified Medicare beneficiary.

(e) To be paid for transportation services that are not paid through the Medicaid Management Information System, a provider must submit to the social services district bills for deductible and coinsurance amounts and the explanations of benefits form issued by the Medicare carrier. A provider does not have to submit the explanation of benefits form to a district which can obtain this information from the Medicare part B fiscal agent's computer files. A district must apply Medicare part B benefits before making MA payments for claims.

(f) Reimbursement is not available under the MA program for services or supplies furnished pursuant to title XVIII of the Social Security Act (Medicare) if:

(1) the provisions of such title or the regulations promulgated to implement such title preclude a provider of such services or supplies form charging a Medicare beneficiary for the cost of the supplies or services provided; or

(2) the provider agrees, under the terms of a Medicare provider agreement, not to charge an individual for the cost of services or supplies.

(g) *Qualified Medicare beneficiaries.* (1) As used in this section and section 360-7.8 of this Subpart, the term *qualified Medicare beneficiary* means a person:

(i) who is entitled to hospital insurance benefits under Medicare Part A;

(ii) whose income does not exceed 100 percent of the poverty line, as defined in section 360-1.4 of this Part, applicable to a family of the size involved;

(iii) whose resources do not exceed twice the maximum amount of resources that the person may have to be eligible for Supplemental Security Income benefits; and

(iv) who meets the nonfinancial eligibility requirements contained in Subpart 360-3 of this Part.

(h) *Qualified Disabled and Working Individuals.* As used in this section and section 360-7.8 of this Subpart, the term *qualified disabled and working individuals* means a person who is not otherwise eligible for medical assistance and:

(1) who is entitled to a hospital insurance benefits under Section 1818A of Part A of Title XVIII of the Social Security Act;

(2) whose income does not exceed 200 percent of the official federal poverty line applicable to the person's family size; and

(3) whose resources do not exceed twice the maximum amount of resources that an individual or a couple, in the case of a married individual, may have and obtain federal supplemental security income benefits under Title XVI of the federal Social Security Act, as determined for purposes of that program.

The challenged regulation, as originally promulgated and codified at 18 N.Y.C.R.R. §360.10, provided as follows:

(a) Medical assistance [*i.e.*, Medicaid payments] shall include the amount of any deductible or coinsurance liabilities under Part A of Title XVIII of the Social Security Act (Medicare) for all eligible applicants or recipients.

(b) Medical assistance shall include the amount of any deductible or coinsurance liabilities under Medicare Part B for all eligible applicants or recipients to the extent that:

(1) When the Medicare payment to a provider of a Part B benefit is less than the established medical assistance fee or rate for the benefit, the Department shall pay the provider an amount equal to the difference between the Medicare Part B payment and the lower of:

(i) the established medical assistance fee or rate; or

(ii) the Medicare approved amount.

(2) When the Medicare payment to a provider of a Part B benefit equals or exceeds the established medical assistance fee or rate for the benefit, the Department shall pay no Part B coinsurance or deductible amounts to the provider.

(c) The Department shall require, as a condition of medical assistance payment of the amount of any Medicare Part B deductible or coinsurance, that the client make an assignment to the provider of any Part B benefit payments to which the client is entitled.

(d) Providers of care, services, supplies or equipment covered under Medicare Part B and the medical assistance program shall accept assignment of a person's right to receive Medicare Part B payments and shall not seek to recover Medicare Part B deductible or coinsurance amounts from such person if such person is also eligible for medical assistance.

(e) To be paid for transportation services that are not paid through the Medicaid Management Information System, providers shall submit to local districts bills for deductible and coinsurance amounts and the explanations of benefits form issued by the Medicare carrier. Providers do not have to submit the explanation of benefits form to districts that may obtain this information from the Medicare Part B fiscal agent's computer files. Districts must apply Medicare Part B benefits before making medical assistance payments for claims.

Medicare Act

42 U.S.C. § 1395cc(a)(2)(A) provides, as follows:

A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1395e(a)(1), (a)(3), or (a)(4), section 1395l(b), or section 1395x(y)(3) of this title with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under par B of this subchapter or which are durable medical equipment furnished as home health services (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). . . .

Medicaid Act

42 U.S.C. § 1396a(a)(10)(E)(i) provides in relevant part that a State Medicaid plan must provide "for making medical assistance available for medicare cost-sharing . . . for qualified medicare beneficiaries . . ."

Section 1396a(n) provides:

(n) Payment amount

In the case of medical assistance [*i.e.*, Medicaid] furnished under this title for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under subchapter XVIII of this chapter.

Former Section 1396a(a)(15) provided that a state Medicaid plan must:

> in the case of eligible individuals 65 years of age or older who are . . . covered by either or both of the insurance programs established by title XVIII, provide where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to such individual under the insurance program established by such title is not met, the portion thereof which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or his income and resources.

Congress repealed 42 U.S.C. § 1396a(a)(15) on October 13, 1988, effective July 1, 1989. Pub. L. No. 100-360, § 301(e)(2)(C), 102 Stat. 683, 749, as amended by Pub. L. No. 100-485, § 608(d)(14)(I)(iii), 102 Stat. 2343, 2416.